Transcript of the Testimony of **IDD-TAC Meeting**

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Case:

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COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

"INTELLECTUAL AND DEVELOPMENT DISABILITIES

TECHNICAL ADVISORY MEETING"

HELD AT:

PUBLIC HEALTH BUILDING

275 EAST MAIN STREET

FRANKFORT, KENTUCKY 40621

DATE:

SEPTEMBER 5, 2018

A T T E N D E E S:

Rick Christman - KAPP
Johnny Callebs - KAPP
Lisa Elstun - KAPP
Chris Stevenson - Leading Age
Carissa Shell - KAPP
Kendra Sears - DMS
Christian Stewart
Laura Sanders - DCBS
Pat Walden - DCBS
LeAnn Magre - WellCare
Marissa Poole - DAIL
Erin Davis - Prime Care Group
Tracy Ruth - Kaleidoscope
Brittany Knoth - PFK
Katie Bentley, CCDD
Kelly Claes - DMS
Pam Smith - DMS
Alisha Clark - DMS
Lori Gresham - DMS
Earl Gresham - DMS
Steve Shannon - KARP
Sherri Brothers - Arc of Kentucky
Mr. Wayne Harvey - KAPP

Elizabeth Kries - DDID

Barb Locker - DDID

David Hanna - Passport

CJ Jones - DMS

MR. CHRISTMAN: I would like to skip to the second agenda item because I'd like Sherri to be here. I'm not sure she's coming but I'd like to give her a few more minutes. And I know this item is important to her, as it is to several other people also here.

So let's go ahead and skip to the second one, at least for now. The general rate increase extended to exceptional rates. You brought that up -- Johnny, did you bring that up?

MR. CALLEBS: I'm not sure, but I just know there were several providers concerned about the 10 percent SCO rate increase that went into effect July 1 didn't automatically go to those who were in the middle of an exceptional rate approval. And I think that was understood and then it had to be requested by the case managers. But even after request it wasn't -- the automatic 10 percent increase wasn't granted. There was some other criteria in there.

And so I think there was just some confusion about how that 10 percent gets applied to people who are, you know, in the middle of an

approved exceptional rate protocol. So, you know, there may be certain criteria that have to be present in order for the 10 percent to be approved, and I'm not exactly sure, but just seemed to be enough confusion about it to try to get some clarification.

MR. CHRISTMAN: Anyone else have an issue in the room about exceptional rate? Anyone?

MR. HARVEY: I brought a couple of examples I'm going to leave with Alisha so her team can go back and research it because we were able to get the 10 percent approved, it's on the PA and everything, we just can't get paid for it.

I don't know if it's just a glitch in the system or not, but what I've got here, Alisha, is the first couple of forms show where you can look into you-all's system and see that it's approved and everything, but then the last page shows what we're being paid. And it's not paying the amount on that.

MR. CHRISTMAN: Any other comments? Let's go back to our first agenda item. And Sherri, our co-chair is here.

MS. BROTHERS: Sorry. I had a conference call.

MR. CHRISTMAN: That's all right. And I know that you -- I think you brought this up several times, this first agenda item about concerns about residential providers not being able to meet needs, and that's a concern we have too.

And I know -- I think it was brought out, and maybe the Navigant study alluded to this, and it's getting to be a problem. In fact, we were talking with another member of the KAPP board, Chris George, who is a behavioral support provider, been for a long time. And he said years ago when there was someone who needed support there was many willing providers and now you can't find one.

And it has to do with the fact that once you take someone in -- once you approve someone for services and later on if you determine that you can't meet that person's need, you have to find another provider before you are able to cease services to that individual.

And consequently, I think what that's led to is a lot of risk aversion on the part of

providers. So I think the problem seems to be getting more acute. And we have talked in here, I think last time we passed a recommendation maybe to look at a third way, maybe there's another service that needs to be between the SCL program and ICFMR. I think this is going to be a real important issue to many of us here and something I think we need to talk about more than just at this meeting. And talk with some people in higher levels of policy -- at the very highest level of policy making I would say.

So I'll be quiet and -- I'm sure there's other people who would like to speak to this issue, you know, Sherri, what are you hearing? And Wayne?

MR. HARVEY: I just know that it's very challenging for providers to serve people any more. Just because there's this expectation that there's -- a never-ending expectation that you would continue to serve someone. Even when you have basically said, you know, hey, we can no longer meet the needs of this particular individual.

We're serving somebody right now that we issued a termination letter on well over a year

ago. And there just doesn't seem to be any hope that that person will transition anywhere else. And we're at risk because we've already said we can't meet the needs of this person but yet we're forced into continuing to serve that person because we're told, you know, obviously that you can't end services. And that's something that as we look at redesign has to be addressed. It has to be addressed.

Because if you look at the SCL waiver regulation itself, it's contradictory in nature because it tells you that you are not supposed to serve someone that you can't serve but yet you can't terminate them. So you know, there has to be something redone there, looked at, you know, thought about.

And I encourage, you know, Cabinet staff to go out and talk to -- because we're not the only provider that's experienced this. This is something that comes up in our KAPP meetings all the time. And talk to different providers that have had longstanding termination issues. Because it just seems like -- because really the responsibility then shifts to the case manager to help, you know, the provider is involved and

takes people to visits and all of that stuff but, you know, the case manager really has to, you know, make that change of service and so forth on the plan and everything and help basically recruit a provider to take that individual. And where they really don't -- you know, they're not the ones that are dealing with all of the crisis issues and stuff that seem to be ongoing around someone that obviously needs a different level of care.

MR. STEWART: So are you having a problem with communication with the case manager in the situation?

MR. HARVEY: No, the case manager is very well aware.

MR. STEWART: You just can't find another provider?

MR. HARVEY: Yeah, there's not another provider willing to take this person. So that's the problem.

MS. BROTHERS: And I think from the family's standpoint they're going into the crisis centers and they're staying for like their limited time and then they're going in and out, in and out, in and out of these facilities.

And there's not enough of these facilities to serve the families or individuals.

And then they're going -- say they stay for their time limit and then they're going out -- they're ending up -- some of them are even ending up incarcerated and other things are happening to them. So we're not -- they're not being served well. There's just not enough. There's not -- we need to create more facilities.

There just needs to be something happening across the state that's not happening to serve our individuals better. And I think that's what we need to be focusing on.

MR. HARVEY: I think what a lot of people miss in serving folks through the waiver program is needs change, needs change through time. You know, most of the time when someone transitions out of SCL waiver program they transition to a nursing home in most cases just because of their age and so forth.

But -- and their needs, their needs have drastically changed but there are a few people that fall in between that that have a different level of need than what the SCL waiver can

provide. And those are the people that are really struggling to be served like she's talking about.

It's a very difficult place to be because as a provider, you know, you don't want to terminate someone, you want to serve everyone that you can; but at the same point when you make that decision and you went there, you know, there is no light at the end of the tunnel because there's no one else for that person to go to. Or there doesn't appear to be.

MS. BROTHERS: Right. And they're calling and they're saying where are you supposed to go? There's nowhere for them to go. And they're asking, you know -- and there's limited facilities across the state on top of that so they're calling from one part of the state and there's only a facility in this part of the state.

So I live here, my child is here. So am I supposed to drive my child halfway across the state to get in this facility? And then what am I supposed to do, two weeks later drive my child back when the same circumstance happens again? I mean, so this is what these families are

facing like every three weeks or four weeks.

So I think that's why I think these crisis -- I mean something just needs to be done for all of these families.

MS. ELSTUN: And the crisis dollars from Comp Care just aren't there.

MS. BROTHERS: Right.

MS. ELSTUN: It just ends up not either being effective or it's not enough.

MR. STEVENSON: Let me ask Wayne, in the particular example of the person you are talking about, help me understand and help everybody understand, what are their needs that need to be met?

The reason why I'm asking, is there a facility that could meet their needs or --

MR. HARVEY: This person needs a change in environment. They're warn out on us.

MR. STEVENSON: Is it behavioral?

MR. HARVEY: Yeah, it's behavioral. But there's nothing that we can do to appease this person. There's nothing that we can do to satisfy this person. This person needs a change of environment.

MR. STEVENSON: So a super

high-functioning individual?

MR. HARVEY: That's the most drastic issue going on with this person. And I don't know what else to do except give that person a change of environment. But the problem is no one else is willing to take this person on and serve them.

MR. STEVENSON: Are they needing another staff person ultimately do you think? Or are you transferring the issue to another person -- they're going to have the same issue but they need increased staffing?

MR. HARVEY: I mean this person is not exceptional rate protocol. I mean we're not receiving exceptional rate on this person or anything. Just because every time we inquire about it we're saying that it doesn't meet the parameters.

MS. SHELL: There is a huge gap, I believe, and we at the agency I work with has just seen this in the past two weeks in the -- I don't know if it's in every area but in our area there's a gap with people who have a dual diagnosis that seem to be extremely -- have extremely high IQs and some real good social

skills to be able to use a lot of behavioral methods to get out of things or to do things or to fight things or to steal cars or do whatever they need to do.

And we can't get them into any other place besides ours. We can't get them into our behavioral health, we can't get them into even Eastern, we can't get them into someplace that will look at the dual diagnosis. And crisis supports, the way we have them now, aren't effective for individuals that go into crisis. And I don't mean the regional crisis team, I mean our staff can't even get enough training on crisis supports. It trains on person-centered but it doesn't train staff on how to be able to protect themselves from getting hit.

MR. CHRISTMAN: If you were going to suggest a solution, do you have a solution?

MS. SHELL: I'm with Sherri, I think there needs to an in-between service that helps. I also believe our crisis prevention/intervention training needs to come away from -- I'm not saying person-centered isn't the way we're going, and I'm not saying things shouldn't be person-centered, I'm saying

that crisis training doesn't need to be all person-centered training and zero how to deal with a crisis.

They want to deal with preventing the crisis no matter what we've done, no matter what the behavior support team has suggested. We're working diligently with our regional crisis team. Staff could never be prepared for an individual, like I said, to steal a car or come up with a makeshift switchblade which I wouldn't have thought of. Staff aren't prepared for that.

So I would say that we need to actually work with crisis services that can help us with that. If we're taking people on that have the higher level of behavioral supports, I mean I would agree to take the person from your agency but you are right, I can't ever discharge them, and --

MR. CHRISTMAN: So you are risk averse?

MS. SHELL: I cannot take that risk. I mean if we took this risk on this gentleman that we're now dealing with so many issues that I haven't even seen in the 22 years I've been in

this field, and there's not a real concrete of how you protect yourself, how you protect staff.

And let's be honest, the rate that we pay staff or are able to pay staff, even with exceptional care supports, does not cover staff feeling like they're going to walk into getting hurt.

MR. CHRISTMAN: Yeah. And I just want to say too, I can't blame the Medicaid services for having this policy because you are in a spot too, you can't have people not have service. So it's really a problem.

So you are saying that things, particularly danger -- dangerous behavior?

MS. SHELL: Yes.

MR. CHRISTMAN: Now, like in our community the police really can't intervene unless they see it. Okay. But I do know in some professions, like for healthcare providers, like if you are an EMT, there is in the regulation -- actually in the law that the police will take your word for it. They don't have to see it to know it happened.

And I'm not sure if something like this could not -- in other words, if they would

recognize our DSPs as healthcare providers -- I'm just throwing out ideas. But I know that danger thing is a problem. And there is a problem with law enforcement, their hands are tied, right?

MS. SHELL: Oh, yes. We were told specifically they will not come back out to that house. And that our individual could never see any consequences because of his diagnosis which is great for -- I mean we fought for that. This is one of the things I had to tell staff, we fought for them not to automatically put somebody in jail, which I don't want somebody put automatically into jail. But now they've explained this to the individual and the individual is now saying I can do anything I want. There's no consequences.

MR. CHRISTMAN: Now, my understanding is if they have a behavioral health diagnosis, and I don't know if this is just in Lexington or not, but if you can show that to the officer, and the officer has been trained and understands what you are talking about, they can be taken, for example, to Eastern State Hospital. They might not be admitted to Eastern State Hospital

but at least they're -- you have diffused the situation.

MS. SHELL: Yes.

MR. CHRISTMAN: You know what I mean? So it's those kind of things, I think, need to be talked about too.

MS. SHELL: I think there's several possible solutions and several areas that need to be looked at in order for agencies to be willing to try somebody new that has a measurable amount of risk.

MR. CHRISTMAN: What do you think, Steve?

MR. SHANNON: We've talked around this for a long time. I was in E-town last year and their chief of police said they need a secure facility. That's what they think is the fix. For not everybody, but a narrow population that you can go because they have one person -- anyone here from Communicare? I mean she calls officers on her cell phone, I mean she's that well known there.

And they really said -- the chief of police said, I think we need a secure place for some folks to go and stay for awhile.

MR. CHRISTMAN: For awhile.

MR. SHANNON: Because they go, they go to the ER there at Hardin Memorial Hospital and they're back home in a very short order of time. And as we've grown I don't think we've figured out the fix for this cadre of people that the SCL program really doesn't have the resources, the capability -- I mean the high intensity rate probably doesn't do you a whole heck of a lot of good.

So I think it's that same -- we're trying to get people into the waiver and that's a good thing, but there are things that we have to look at that we don't have available today that would be a better utilization of resources.

Hopefully our friend at Navigant is at least having conversations about this group of folks who really, their support needs exceed what's available in the SCL. And all you providers, I'm not a provider, you know, serve these folks who are challenging and try to make it work. Right?

MR. CHRISTMAN: And I'm sure we all agree, even though it's an exceedingly small number of people, it takes up a lot of time.

MR. SHANNON: Yes.

MR. STEVENSON: The whole idea behind the Olmstead law back in '99, '98, is that there were not many options. It was all institutional facility-level care so when the DOJ, Department of Justice, came in and said we need to go into these states and then they created these options, which was great, the idea wasn't to eliminate the ICF, the intermediate care facilities, the idea -- and what they found is that when states were discharging folks into the community without the appropriate level of intermediate care in terms of behavioral or health, these people were left with unfunded care in the community and they were facing a crisis.

I mean it was the reverse crisis. So they weren't getting their needs met in the community. I think that's what we're talking about here. DOJ, they were never intending for facility-level care to go away. The idea was to have multiple options, that's my read on it. That's the study that I've done, and you will see that on the DOJ websites.

But you have to understand that what

Kentucky needs to do now is focus on that in between that we're talking about here, you have got to look at and create -- and like Steve was saying, the chief of police saying look there needs to be a facility. It's not to unduly segregate them, it's because they need that. Even if it's for a small period of time.

Just like for Cedar Lake, we're fortunate that our private organization has waiver services and private intermediate care. And trust me, when you walk into these facilities they're not institutions. And I think any of you that have ever toured Cedar Lake facilities knows that's very much a home to them. And we've done some renovation that's wonderful.

But we're fortunate because people in the community, as they start to age and have all of these significant medical or behavioral, they shift from their apartment home or regular SCL home into the intermediate care facility where there's a lot more folks that can help with their needs. And then if they can transfer back into the community, they do that. We're very blessed to have that, but not many providers have that. And I think that's what's needed is

those facilities to be able to go into --

So I think we need to figure out how to create a forum for this discussion. We've talked about this before.

MR. CHRISTMAN: It's probably not this group.

MR. STEVENSON: It needs to be a separate group.

MR. CHRISTMAN: Maybe that could be a recommendation, a focus group or something --

MR. SHANNON: This population -- I think a lot of folks age out of Home of the Innocents and it always fascinates me. I know exactly what happens after age 21, it's age 22. It's not a secret.

We have folks at Home of the Innocents that we don't have a plan for. And they're aging out.

MR. CHRISTMAN: And everybody knew it.

MR. SHANNON: Everybody knew it. But there's pockets of folks who have much greater support needs that -- the SCL program can provide a wide array of support for people but maybe not everybody, you know.

MR. STEVENSON: To your point, the social worker from Cedar Lake and the social worker from Home of the Innocents got together and they brought the crisis to me, this was five years ago, and I spoke to Gordon Brown at the time when he was the CEO. But the statistic they shared with me, Home of the Innocents shared, that three or four out of ten were passing away within 18 to 24 months of discharge at the age of 22, 23 because of the inappropriate level of care. Nursing home care could not do it. The ratio was way too high. We're talking kids that were even on ventilators. There's not appropriate services.

So that's a subsection, absolutely that -- just like Home of the Innocents has created a unique subsection within the state health plan, which is nursing home for kids, that's kind of what it's called, something else I think it's called. But to create something in the state health plan that could be unique in meeting diversion population's needs I think is something we should look at. And I agree that it can be discussed here because we need more traction if we put the -- get the right heads in

the room.

MR. CALLEBS: A formal recommendation did come out of this committee and it was presented to the MAC, and I don't think there's been a response to that.

MR. CHRISTMAN: Right. But this to me is even more specific that we're talking about here. I think we're talking about developing a focus group or a work group which is taking this to another level, would you agree?

MR. STEVENSON: Absolutely. And I thought that we did mention a focus group, but maybe we didn't.

MR. CALLEBS: Just to serve the gap. A fundamental premise of the waiver system is protecting health, safety, and welfare. So if you have an unsafe, unhealthy situation that a person is in, their needs are not being met and everybody knows it, we have to act to do something to fix that.

MR. CHRISTMAN: Fix that, give people the tools that they can deal with it or come up with something else or whatever.

MR. CALLEBS: It's not okay to wallow

around in this for 12, 18 months, two years, two and a half years.

MR. CHRISTMAN: It seems to be getting worse.

MR. CALLEBS: People cannot get the help that they need.

MR. SHANNON: And this issue has been discussed by members of the general assembly as well. It's not a secret.

So it was suggested at one point a task force from the general assembly to look at this. And that never got traction, but just the idea that this conversation is taking place in many places.

MR. CHRISTMAN: But no one has come up with really good ideas on how to fix it. We need to take it to the next level and have some recommendations -- identifying the problem is not enough.

MR. SHANNON: The solution is money.

MR. STEVENSON: It is.

MR. SHANNON: I think we can all figure out the support needs folks need, but we can't do that --

MR. CHRISTMAN: But it's not all

money if it involves law enforcement. It's not all money I don't think.

MR. SHANNON: But even with law enforcement they have got to come back someplace. Law enforcement isn't going to change people's behavior. It takes greater support needs to maintain people, and that's fine, we just have to acknowledge that 168 a day or 173 a day is not the trick.

MR. CHRISTMAN: But you don't want your people coming to work afraid.

MR. SHANNON: No, you don't.

MR. CHRISTMAN: And there have been people killed.

MS. BROTHERS: But you also want to think about your families and your individuals and can they get the proper supports that they need in these facilities and then come back out and come into the communities after this -- I mean you want to make sure that you are providing them with the proper supports, whatever that takes, in whatever facility that we need to provide across the state. Because our ultimate goal is for them to come back into the communities and be able to serve them well.

MR. CHRISTMAN: I agree.

MR. STEVENSON: I know that there are certificate of need beds that have been unfunded. And help me out, do you know how many certificate of need beds, ICF beds, are in inventory that are not being funded currently?

MR. EARL GRESHAM: No clue.

MR. STEVENSON: My understanding is that there were around a thousand beds but 500 of them plus are currently unbudgeted but they're in inventory on a shelf. Basically they're still certificate of need beds and you need a certificate of need to create the facilities that we're talking about. If there's a way that we could speak to the Cabinet about how do we get creative about taking some of those out of inventory and creating a -- not a super robust facility model but something that will give the appropriate funding, and sometimes you need the certificate of need bed to make that happen. It's beyond waiver.

MR. CHRISTMAN: It's interesting though, if you are talking about people who have -- the real problems are folks with -- their disability is rather limited.

MR. SHANNON: Correct.

MR. CHRISTMAN: How are you going to keep them there in any facility? I don't know. Well, does someone want to make -- so I think we've been talking about perhaps asking the department to develop a work group, does someone want to put that into a motion?

MS. BROTHERS: Task force.

MR. STEVENSON: I'll make a motion that we suggest to the MAC the creation of a task force to include providers, families, executive and legislative branch members --

MR. CALLEBS: All stakeholders.

MR. CHRISTMAN: Including DMS.

MR. STEVENSON: Right. So we can simply say all stakeholders to discuss meeting the needs of those that go beyond the waiver.

MR. HARVEY: Do we want to say discuss or come up with ideas to address the issues?

MS. BROTHERS: Solutions.

MR. STEVENSON: To develop solutions to meet their needs.

MR. CHRISTMAN: It's a little jumbled.

MR. HARVEY: Come up with proposed solutions to meet the needs.

MR. CHRISTMAN: Does everybody understand the motion?

MR. HARVEY: I don't think one idea is going to fix this issue. It's going to be multiple things moving over multiple spectrums. You know, I think for waiver providers, you know, a start is looking at, you know, the regulations and stuff around termination of services and stuff.

And how, you know, one part of the regulation contradicts another part of the regulation when you are looking at that particular piece. You know, that's a start for waiver providers in regards to what they have to answer to for their own regulatory entities and so forth.

You know, is there a part that law enforcement plays in this, as Rick has alluded to, I'm sure there is. I'm not really clear on what that would be, but that's why we're saying we need to look at forming a task force because somebody from law enforcement might be able to tell us those things and might be able to share

with us, you know, what their full scope of abilities are.

MR. STEVENSON: I wrote something down here if we want to officially have something.

Creation of a task force made up of multiple stakeholders to address the intense medical and behavioral needs of individuals that go beyond what the waiver can provide.

Does that sound okay?

MR. HARVEY: I second.

MR. CHRISTMAN: Any other discussion? All in favor?

ALL PRESENT: Aye.

MR. SHANNON: I think folks who serve on 144 ought to bring that to 144 as well.

MR. CHRISTMAN: We're going to work on that.

MR. SHANNON: They meet on the 14th.

MR. STEVENSON: We might want to have a joint call.

MR. CHRISTMAN: We've discussed that a little bit already, as a matter of fact.

Okay. So we'll skip down then, that was a good discussion.

Eligibility related to Map 552 issues and individuals in the waiver program being placed in the wrong plan.

Is that you?

MR. HARVEY: I think several providers came up.

MR. CHRISTMAN: So you can speak to that?

MR. HARVEY: I can a little bit. What we've been experiencing, and it seems to happen a lot around the time for renewal of an individual's plan, for whatever reason, you know, they get placed out of it. And forgive me for the name of these plans, but there's an Optimum plan and a Global Choices plan or whatever.

And it seems like more often than not people in the SCL waiver program, for whatever reason, get placed into the wrong plan. And it takes weeks upon weeks to get that corrected and fixed. And a lot of times, I know when our billing office is inquiring with Medicaid they're saying it's a 552 issue, you need to check with your local DCBS office.

So we'll send staff down to the local

DCBS office, or if we're fortunate enough to have a case manager that's willing to go by there and check on the issue itself then we'll do that. And then we're told at the local DCBS office that it's not a 552 issue, everything looks good. It's the dog chasing its tail sort of example occurring over and over because, you know, we're told one thing at one entity and told another at another entity and all the while the problem is not getting solved. The person is still in a nonbillable status because they're in the wrong plan. You know, that's the issue. What all is causing it? I don't know.

MS. ELSTUN: Just from my experience, you actually have to ask one of the workers, Do you have experience with adult medical? First of all, because that's what I've learned is some of them are new staff, they haven't been trained completely, they're not fully understanding what that means.

So you have to kind of -- because I know I went through this at the Boone County office because they went through such a staff turnover that there was like one staff left that knew how to do adult medical and the two new ones, the

one tried to help me and ended up messing up the whole process so the one that had the most experience had to go back in, correct it, had to physically go to the office, sit down with her and go through the whole thing for the person, because it was like three months.

And then you have to make sure that they put in for a special circumstance and backdate for that three months. It's a whole process of making sure you are talking, first of all, to the right person because that's what I've been dealing with a couple of our folks is just dealing, first of all, with the right person.

MR. HARVEY: A lot of circumstances family will come and get the individuals themselves and take them to these appointments. You know, the provider is not even there in some circumstances.

MS. ELSTUN: Right. And we have just started kind of communicating with our families and having them sign the Map 14 to help represent because that's been the easiest. Because the parents or families or guardians, they end up getting so confused about what they need to bring, what's supposed to be submitted,

all of that. So we have just kind of started taking the initiative and having them do the Map 14, gathering the information from them and going to the office to help represent them. Even if we're not the payee for that person.

MS. WALDEN: So a couple of things to keep in mind is that adult Medicaid, that's Medicaid for the aged, blind, and disabled, is specialized. So not all workers are trained on it or will be trained on it.

So most offices have at least two or are supposed to have at least two, but DCBS has a high turnover rate. People come and go all the time. The other think to keep in mind is that the worker has absolutely nothing to do with what plan they're in, you know, action is taken by the worker that may lead to what plan they're in but when you start telling the worker they're in the wrong plan they have absolutely no idea what you are talking about. They have no way of knowing what you are talking about because there's nothing on the eligibility system that tells us what plan they're in. That's on the Medicaid billing system.

So one of the things I know does happen,

because you said it's happening lots of times at the SCL renewal is that they get a 60-day grace period. So in the system if their level of care ends, let's say May 19th, then they'll get a 60-day grace period. If we don't have a new level of care by July 19th, give or take a day or two, then their patient liability will stop. And if they're otherwise Medicaid eligible, an SSI recipient or passthrough or something, then yes, their plan is going to switch to managed care because they no longer have that patient liability and there's nothing the DCBS worker can do to fix that. It's just a waiting game for us to get that interface with that LOC.

So without case numbers and without being able to look at individual cases, we can't really tell you what the issue is because, yeah, it could be something that needs to be done on that case. Sometimes everything is right in the case but the information doesn't pass over like it should.

So there are just multiple things that could be causing that. And you know, without knowing exactly -- looking at each individual case, we really can't tell you.

MR. SHANNON: Is there anything the case manager or provider can do to expedite the resolution? Because the story is they're getting SCL services for an extended period of time and you-all can't bill; right?

So is there anyway to fast track those -- because you know, I've been hearing this story -- well, going back to 2011, people in a waiver getting assigned to a managed care company. It impacts their access to health insurance because now they have to go back for prior auth or whatever. But the residential program, the day program gets nothing. And it's -- it takes months to get resolved; right?

MS. WALDEN: The only way I know to fast track it is to send it to my branch, and that e-mail address is dfs.medicaid@ky.gov. Because like I said, when you are calling Medicaid member services they're looking on their end and they're saying must be something on the DCBS side. The DCBS worker is looking on their end and they're saying everything looks correct in our system so I don't know what's wrong.

So usually it's up to my branch to have

to look at it and say, yes, everything is correct on the worker part of the eligibility system. And then we send an e-mail and tell them they're going to have to manually push it through. Or we look at it and we say this and this or this needs to be done. Or you know, I mean that's basically the best way -- the only way I know for you to expedite it. A lot of times when you go into the local office, the local office will send us an e-mail and say, you know, they've been in and asked about this case, everything looks correct on our side but they're saying they can't bill.

But you know, probably that doesn't happen every time. I mean, Laura, do you have any other suggestions?

MS. SANDERS: No, not really.

MS. CLARK: Another way to help prevent them from going over into managed care is the case managers get a task 60 days out to do the LOC, getting that done quickly is very important. And then 45 days out they get a task to do the plan of care, and getting that done.

I have seen cases where they're waiting until the last day to submit LOCs, and then you

have to wait until that is approved, so then there's LOIs, not all of that information will transfer to our claim system until all of that is resolved which is, you know -- if you do it when you are allowed and receive those tasks it's going to help prevent --

MS. ELSTUN: Right. We've started kind of reaching out to the case managers, hey, their plan is coming up. Hey, can we get this scheduled? Kind of pushing the case manager, but in a sense yes, so we make sure that those things are scheduled, we know it's going to happen. We're not waiting for them to call us to schedule it. And it's nothing against the case manager, we're trying to stay on top of it so we don't develop the billing issues. That's the only solution that we've come up with to this point.

MS. WALDEN: So that might be a good place to start if you look at that when you are not able to bill. When did they do their LOC request, when did they start it? If they didn't start it until the last minute then that's a good possibility.

And once they flip to managed care, I

don't think they flip back until the next administratively feasible month, so it could take two months.

MS. CLARK: But as long as the level of care and waiver details are on file and the patient liability is on file, which that can be viewed in Kentucky Health Net, and they have eligibility, no matter what plan, if it's Optimum or Comprehensive or Global or an MCO, they can still bill and receive payment. But it is that next feasible month. And that's based on an eight day business rule because of capitation payments to the managed care companies. So depending on when that's fixed in a month it could take two months.

MS. WALDEN: Right. If it's fixed after cutoff then it will be the month following the next month.

And I do want to say because we're talking about Map 552s here, they have stopped issuing Map 552s just so you know.

MR. CHRISTMAN: Is that kind of related to the Benefind problem we were dealing with several months ago? It sounds like it's better than it was. Now it's down to a matter

of execution by the case managers.

MR. SHANNON: We've had this problem going back seven years.

MR. CHRISTMAN: But it used to be worse.

MR. SHANNON: Well, right. Benefind -- this happened before the Benefind thing.

MR. CHRISTMAN: So it's not really the Benefind.

MR. SHANNON: No, it's been an issue that I've gotten calls about for a long time.

And I don't know what -- I think you are right. We need to trigger case managers to go ahead and -- so you don't run up against that 60 day window.

MS. WALDEN: There's multiple problems on both sides I think. But like you said, that's the e-mail address, dfs.medicaid@ky.gov. And we track and log everything so that's usually the best place to start.

Now, I will say, try the local office but I'm saying --

MS. ELSTUN: And we've built some good relationships there.

MS. WALDEN: Because we get lots of e-mails so we don't want to be the people you start with on the basics, you know, once you have got something where they're both telling you everything looks right in our system.

MS. ELSTUN: We're also running into the issue with some of our folks where their elderly parents have recently passed and if they were collecting off their social security benefits, they're getting -- we're running into issues on that end where all of a sudden social security has booted them out or they've -- we had one gentleman they confused his mother's death and said he passed.

So if you are having issues, you know, it might stem from the social security as well if they just recently had a parent pass.

MS. WALDEN: Yes, because if they lose their SSI -- we do have a process, we do have a process where we get a task for anybody that loses their SSI because of the increased income to determine whether or not they're eligible for passthrough.

But if they lose it for another reason and we don't get that task then they have to

come in and apply as a non-SSI recipient.

MS. ELSTUN: I've been educating myself all over the place.

MS. WALDEN: We do have an automated process for if someone loses it due to increased income to determine whether or not they're eligible for passthrough; but if we determine they're not eligible for passthrough, again, they will have to come in and apply as a non-SSI recipient.

If they appear to be technically eligible as passthrough, then we give them what we call presumptive eligibility. It's not the true Medicaid presumptive eligibility, we presume -- we know that they're technically eligible for passthrough and we presume they're income eligible and then they're scheduled an appointment to come in three months later.

MS. ELSTUN: Right.

MS. WALDEN: But we do have some processes in place for those.

MR. CHRISTMAN: Thank you. Update on client liability payment process. We've gone back to how it used to be in liability, patient liability, is that my understanding?

MS. SMITH: It has reverted back to what it was prior to the changes that were scheduled for August 1st. We still are in the process of doing all of the fiscal impacts for what potential changes would be.

So those are not ready to be shared yet. But we are looking at that.

MR. CHRISTMAN: Anybody else have any other questions?

MR. HARVEY: Do you guys have any kind of timeline? Because we've got people asking us what happened to all of this change that was supposed to happen and now it hasn't happened.

MS. SMITH: I don't have an exact timeline. We do have some deadlines to report back to the MOAC, so it will be -- we'll have to report back to them and there will have to be several levels of review before we can release it to providers and to individuals.

But there will be communication that will go out to both that will explain what the final decision was and what any changes are.

MR. CALLEBS: Pam, is there a -- so currently then the primary provider for the

person will have the patient liability?

MS. SMITH: Depending on which waiver they're in and which service they're receiving within that waiver as to how much is collected.

MR. CALLEBS: So if you get residential and SCL, for example, then a residential provider will face the patient liability deduction in their payment or --

MS. SMITH: Right.

MR. CALLEBS: Or if they are in Michelle P. and only get day training and case management --

MS. SMITH: Michelle P. is the case manager only.

MR. CALLEBS: Thank you.

MS. BROTHERS: Some of our individuals with the patient liability, they were facing like quite a bit of liability, and it seemed like they were getting affected as far as like not feeling like they could pay their rent and facing a lot of charges with this patient liability.

MS. SMITH: That is why it was remanded, everything was remanded back to be reviewed again as well.

But that is there -- I mean it was looking at the current post-eligibility income rules and that was what was determined to be their patient liability. That's why we encouraged everyone if they felt like something was not -- that it didn't look right, a lot of people did not provide all of the documentation if they had other deductions that could be -- that could be figured into that.

So that's why we had encouraged people to check on that as well. But that was part of the main reason that we remanded that change to go back and look at other options.

MS. BROTHERS: Okay. We've encouraged all of them to come forward. I think they've been coming forward and talking to the Medicaid person.

MS. SMITH: I know we've talked to several people and I know I've worked with Laura and Pat both, and I know all of us have had calls and have talked to individuals.

MR. CHRISTMAN: Now, I understand there was another thing we had talked about relative to this is that apparently states have the ability to really reduce patient liability.

MS. SMITH: That's what we are looking at all of the options. We're looking at our states that are similar to us, we are doing our due diligence to research what the best option is both for the individuals and for the programs.

MR. CHRISTMAN: Would that necessarily involve a change to our state plan that would take awhile?

MS. SMITH: It depends on what the change would be.

MR. CHRISTMAN: So that's all really kind of up in the air?

MS. SMITH: That's why we really are taking our time and looking at everything and all of the options and what each one will require.

MR. CHRISTMAN: Okay.

MR. CALLEBS: Could involve waiver amendments?

MS. SMITH: Potentially.

MR. CALLEBS: Pushing the thresholds to 300 percent or something like that.

MS. SMITH: Potentially.

MR. CHRISTMAN: Which would solve a

lot of the problem.

MS. SMITH: That's why we truly are looking at all of the options.

MS. DAVIS: I have a question, how is primary provider defined? If you said that with Michelle P. it will always be the case manager. So if someone's SCL and they have case management and they have ADT and they have psych, but they live at home, so is that base --

MS. SMITH: It's the case management.

MS. DAVIS: Okay. So that's based on how many hours they bill --

MS. SMITH: It is truly based on a set of rules that were created many, many years ago that I honestly do not have a good answer for who determined who was going to be the primary provider. But that's what it was determined many, many years ago and we just have continued with that same methodology.

MS. DAVIS: I think it would be beneficial if, in my opinion, if when you go to issue your letter that like primary provider be defined so people kind of understand.

Because in the past we've been told, in other situations, that we were the primary

provider for someone who lived at home for underneath the SCL even though it wasn't the case manager. So just to avoid confusion.

MR. CHRISTMAN: Good. Thank you for looking into that. That's great.

Update on residential agreements -- or residential or lease agreements with DAIL for compliance with final rule requirements.

MS. LORI GRESHAM: I have requested a meeting with guardianship to discuss that. So we're waiting on them to set that up.

MR. CHRISTMAN: Thank you.

MR. LORI GRESHAM: You are welcome.

MR. CHRISTMAN: Update on process for approving applicants to fill available Michelle P. slots.

I guess we still can't believe that that's taking so long to fill. I know you have explained this many times.

MR. EARL GRESHAM: Well, we were preparing to send out some denial letters, and we spoke to legal as we were doing those letters and legal missed part of the regulation and we're unable to proceed at this time.

MR. CHRISTMAN: So have you stopped

reviewing applications or --

MR. EARL GRESHAM: We have at this time, yes.

MR. CHRISTMAN: So it's all --

MR. EARL GRESHAM: It's all on hold and we're looking for another avenue now.

MR. CHRISTMAN: It only gets worse.

MR. EARL GRESHAM: It does.

MR. CALLEBS: In the meantime there are still hundreds of funded but open Michelle P. slots that just can't get filled because we're trying to work out the legalities of it.

MR. STEVENSON: How many slots?

MR. EARL GRESHAM: There are more allocations that will be issued within the next 30 days.

MS. CLARK: And we're having to go through because we have found that case managers, in some instances, have not disenrolled individuals. So we ran reports, we have nurses going through those matching things up, we're reaching out to case managers asking them to put in the disenrollment for their last date of service. So we're doing a clean-up effort.

MR. CHRISTMAN: So there may be more open slots than we're even aware of?

MS. CLARK: No, based on what we -- the system was telling us we had a whole lot less than what we thought. And so we're working to get the system, based on our claims data, because we're got a couple of different reports that we pull from. So our claims data was giving us one piece but then we have found that, of course, the claims data doesn't match the system because an individual doesn't have a plan of care so there won't be any claims for them.

MR. CHRISTMAN: Okay.

MR. SHANNON: What's the number of allocations offhand?

MR. EARL GRESHAM: That we have available?

MR. SHANNON: Yeah.

MR. EARL GRESHAM: Around four or five hundred.

MR. SHANNON: And you said the next 30 days some will be coming out?

MR. EARL GRESHAM: Probably about 250.

MR. CALLEBS: That will be allocated?

MR. EARL GRESHAM: Yes.
MR. STEWART: And that's still a total of 10,500?
MR. EARL GRESHAM: Yes.
MR. CALLEBS: And the remaining of the four or five hundred and the 250 being allocated, so that would leave 200 to 250 remaining, and is it those -- that group that will be tied up in the legal matter?
MR. EARL GRESHAM: As we go through and make sure that those slots are either in the administrative hearing process and they're being held for that reason, or like Alisha discussed, going through and making sure that the ones at MWMA truly need to come out and they're disenrolled. So I allow a cushion to make sure that we don't go over our slots, because if we go over our slots then we have to pay a hundred percent state funds.
MR. CALLEBS: Okay.
MS. BROTHERS: What was the total number on the waiting list, what did you say?
MR. EARL GRESHAM: I haven't said.
MS. CLARK: That was not on the agenda. If you will ask me at the end of the

meeting I'll get it for you because it wasn't on there.

MS. BROTHERS: Thank you.

MR. CHRISTMAN: Updated SCL wait list and available slots.

MS. KRIES: There are currently 2,340 people on the wait list and there are 142 in the urgent category. And at this time we have 80 available slots.

MR. SHANNON: And those slots are?

MS. KRIES: Emergent.

MR. SHANNON: And that's from slots that were not used the prior year; is that true? The source of those 80 slots?

MS. KRIES: That were vacated.

MR. SHANNON: So that's 80 slots until April?

MS. KRIES: Through February.

MR. STEWART: So those are 80 funded slots.

MS. BROTHERS: Did you say through February?

MR. EARL GRESHAM: February 28th or 29th, whichever one it's going to be this year.

MR. CHRISTMAN: Thank you. Waiver

redesign update including rate study.

MS. LORI GRESHAM: So we are currently awaiting the final draft of the recommendation report from Navigant. As you know, we did our public comment period and they went back and are adjusting their recommendations based on stakeholder involvement.

So we're awaiting that. Once we receive that we'll process that internally and then blast it out to all of our stakeholders at large. And then that will also include the process and the involvement of stakeholder input with that, so everybody knows how to discuss that with us and those kind of things.

Specific to the rate study, we have confirmed that the rate study is a recommendation that we will be accepting. And we'll be distributing information about that towards the end of the fall. It will include things like a provider survey to discuss reasonable cost and those kind of things, to really do an in-depth study of what true cost is for providing services through our waivers.

MR. CHRISTMAN: Just to make sure I

understand, so you are waiting initially now to get something back from Navigant based on what you told them to work within these parameters -- you basically took the public comment, digested --

MS. LORI GRESHAM: They took the public comment and digested it for their recommendations and then will give us a final copy of their recommendations to say here is what we believe, including stakeholder comment, here is what we believe that Kentucky should do. We will then review those and determine --

MR. CHRISTMAN: You being DMS --

MS. LORI GRESHAM: Not me specifically, well, I'm sure I will.

MR. CHRISTMAN: -- will review it and then it will go out.

MS. LORI GRESHAM: Because we want to be able to answer questions if people ask them. So we'll review it and then submit their recommendations. We won't change that. It will be their document. Submit that out to the public at large and say here is their recommendations.

And then Kentucky will go back and our

governance team -- and we have a very robust governance team, it starts with Division of Community Alternatives, which is the waiver branch within DMS, we'll review it and we'll talk with our agencies. We meet frequently to discuss recommendations, to discuss ongoing things.

We'll meet with management of all of the branches and we'll also meet with our executive leaders that include staff from the governor's office to determine which of those recommendations we'll accept, which we'll push off until later, what's feasible, what's not feasible, and devise a plan for how to implement those.

And then we'll release that. One of our main focuses is to ensure that as we release that that individuals who access those services understand what those changes mean. So the report will come out and it will be this giant document that nobody will understand, not even folks who sit in DMS, because it will be so massive.

But then our hope is to break that plan down in smaller chunks so that individuals can

digest it easier and understand, this is what this specific change means to you and your waiver, this is what this specific change means to you and your waiver.

Our team is very dedicated to making sure that individuals who utilize and assist with those services understand the process and what any changes mean.

MR. CHRISTMAN: And of course, Navigant, we all know they had some recommendations or -- before it went out for public comment. And you just heard the discussion we had earlier about, you know, the third way or whatever, do you think that's -- in other words, do you think what Navigant has already put out there would encompass what we just talked about in your opinion?

MS. LORI GRESHAM: I believe so, if you read the initial draft of the report. One, everybody knows that there's issues in our waivers, for instance, SCL and Michelle P. are so vastly different that somebody who administers Michelle P. and SCL -- it's a nightmare to do those two. So looking at our waivers across the board and understanding that

those waivers, while they target specific populations, touch all across the board.

So kind of looking at first round streamlining those and making sure that we have the best waivers we can so that we can really do a good assessment on, are we serving the right people, are we providing the appropriate services to those people. And then looking at the restructuring of those waivers.

So what you will likely see is the first step will be the waivers we have, making those better. Streamlining them, making sure that we can extract data. As everybody knows it's hard for us to get good data because everything is comparing apples to oranges across the board.

So understanding who we serve, are they the appropriate people? Do we have good data to support what we're doing? And then along with the rate study understanding are we reimbursing appropriately so folks can provide quality care?

And then the second round looking at how do we increase quality, how do we ensure we're serving the right people, and streamlining that and doing those things. Does that make sense?

MR. CHRISTMAN: Still a lot to do.

MS. LORI GRESHAM: Still a whole lot to do. Lori will stay busy for awhile.

MR. CHRISTMAN: Okay.

MR. CALLEBS: Is there a target date for the rate study to be completed once it's initiated?

MS. LORI GRESHAM: What Navigant has told us that typically that's at least a year-long look-through -- and that includes the initial survey to talk to folks and say, tell us about what you have, which that's why when we did the town halls we put out that provider letter that said these are the things that Navigant may ask for so that for bigger providers it may be really easy to pull that information, they have the automated system. But we wanted to ensure that our mom and pop agencies could understand down the road here is what you are going to need so they could start brainstorming how to provide that information.

So we'll have some type of survey. Navigant has done this in lots of other states. They've even done it in Kentucky on the other side of the house. So they'll really be pushing this forward because they're the experts in

that. I don't pretend to know -- I'm a nurse, we don't do math other than to know what medications to give. But they will push that forward and really work to make sure that we have a good understanding of true cost to provide services.

MR. STEVENSON: I had a question with regards to Michelle P., our case manager recently told us that as of 1 September that services would be, I guess, bundled versus unbundled or vice versa.

So in essence with CLS hours, you either use it or you lose it, essentially, that was the bottom line. How did this come about and, you know, how did this happen in the midst of waiver redesign? Or is this something that legal looked at and in retrospect said you are not doing that, you need to do this?

MR. EARL GRESHAM: So in, I believe it was May 1st, we moved CDO to PDS. It was -- what happened is prior a budget would be requested -- I'm trying to remember because it was kind of a lengthy process -- so the budget would be requested, it would go to DAIL, DAIL would look at it, do what they do, then it would

come to us, my staff would look at it and look at historical information to see how much that budget was going to be.

And in some of the waivers, especially ABI, historical data would be $7,000 but they needed a budget of $70,000. So we would award the $7,000 and then they would have to do a budget exception to get what they truly needed. So it was a long, drawn-out process that took two or three months.

Now, the budget goes through MWMA to Carewise, and Carewise reviews it and either approves or denies. So the timeline is much shorter. In doing that we unbundled the codes so they could be tracked better, we could get better data. And the process has improved in the amount of time it takes to get approved.

MR. STEVENSON: But, for instance, I guess specifically with PDS, Michelle P., so why now are -- you know, for instance, if you are given 35 hours a week, in the past you were -- if you didn't use that 30 hours you would be able to have access to those hours all throughout that budget year. Now, because of the change, we're being told that if you don't

use those hours then those hours are gone and you can never go back and get those hours and use them.

Now, you still can for respite, but for CLS specifically you can't go back and utilize any of those hours in the past.

MR. EARL GRESHAM: You can still only use 40 hours a week.

MR. STEVENSON: Correct. Yes. So for instance, if you don't use 40 hours, what we're being told now is that because of the change in the service, the way it's administered, that if you don't use those 40 hours then those 40 hours, whatever you didn't use, they're gone. You can no longer dip back in to grab some of those hours.

MR. EARL GRESHAM: As long as you don't go over 40 hours a week it shouldn't matter. Like if you only scheduled 20 one week and you needed 40 --

MR. STEVENSON: Right.

MS. SMITH: So the difference now is that you -- and actually it had been this way all along you should be -- it's what you need. So you need this many units of CLS a week and

this many units of personal care a week.

So you really, all along, shouldn't have been able to -- as Earl was alluding to -- flex those units back and forth. Now, if you request so many a month, you have that whole month to use those, and as long as you don't go over 40 then you use those however in that month -- you say you need 50 a month, you get that whole month to use those 50 units as long as you don't go over the 40 hours a week.

But there should have never been any kind of, I'm going to set this aside and I didn't use it, now I'm going to pick it up this week. Because there was always a plan turned in that said we want to use this many units of this service and this many units of this service.

At anytime if something changes, a case manager can submit a modification, if there's something that changes.

MR. STEVENSON: So I guess then why was it changed? You know, previously you had all year to dip back into that, so why is it now a month?

MS. SMITH: So honestly, previously you didn't have all year to use that. It was --

you had a monthly budget and you had -- it was supposed to be based on the plan that was sent in when the budget was established.

So it's not like you were given $40,000, okay, use it however you want for the entire year. There always should have still been the team meetings, should have still been the planning, should have still been -- and we encourage when you are planning services, if it's something that you can request on a monthly basis, do that because that does give you a little bit of freedom if you need more personal care one week than you did CLS, then you are able to -- within that month -- use those units how you need to versus if you request it weekly it's Sunday to Saturday for that week. And you lose, if you don't use those units for that week then they are gone at the end of that week.

MR. STEVENSON: Okay.

MR. EARL GRESHAM: But you are still capped at 40 a week.

MS. SMITH: You are still capped at 40 --

MR. STEVENSON: If I have 160 a month I can't go zero one week and 80 the next?

MS. SMITH: Correct. You're still capped at the 40 hours a week and still capped at the total budget amounts that you can have.

MR. STEVENSON: You can bank respite hours?

MS. SMITH: Respite, the only reason it's different -- and each waiver is a little bit different is it's more of a PRN service. So you don't know that you are necessarily going to need respite so there's a $4,000 cap on respite so you can use -- however you use that, you get that $4,000 and it's gone for Michelle P.

MR. STEVENSON: I guess that's where I'm still confused, because, for instance, when the services -- our provider was telling us that when services went from being bundled to unbundled this summer they submitted a brand new budget for us and so our services were frozen for several weeks until that new budget came back.

That's why -- I don't know if we're -- to me it didn't make any sense because I didn't know of anything like this that was happening.

MS. SMITH: We can look at that individual's situation if you want us to, but

that shouldn't have been the case.

MR. STEVENSON: So really there were no changes this summer?

MS. SMITH: The only change was instead of it being S5108 for four different services you now actually -- it shows exactly which code you are billing for and exactly how many units, that just gives us, as Earl mentioned earlier, better insight into what's being used, how much is being used. So that we can administer the program better.

MR. STEVENSON: So this month has always been in place, it's not something new.

MS. SMITH: Always.

MR. STEVENSON: All right. Thank you.

MR. SHANNON: Was it enforced though previously?

MR. STEVENSON: It didn't seem to be because in the past -- well, I guess prior to legal weighing in on the 40 hours in the actual policy -- or the Kentucky state code for -- what's the word for the Michelle P.?

MR. SHANNON: Regulation maybe?

MR. STEVENSON: I guess a few years

ago when that was -- prior to that being enforced, you could certainly use -- you were using more than 40 hours a week.

MS. SMITH: It has actually been in the regulation, it was not systematically enforced until --

MR. EARL GRESHAM: April of 2015.

MS. SMITH: For three years it's been systematically enforced but the expectation and the regulation had always stated that.

MR. STEVENSON: But I know there's been several times where we've been able to dip back into more than a month to utilize it. So that's why this year our case manager specifically said, you can no longer do that. Actually, she told us you have two weeks. You have the pay period, and that's it.

MS. POOLE: What agency is that?

MR. STEVENSON: Centerstone.

MS. POOLE: Because I can reach out and we can talk to them.

MR. CHRISTMAN: All right. Does anyone want to speak to the final agenda item, experiencing delays in background checks.

Is that -- I think Shannon had that on

and then she's not here. Does anyone want to speak to that as an issue, background check delays?

MR. HARVEY: I've been hearing stuff from providers.

MR. CALLEBS: I don't know if they're talking about the --

MS. CLARK: I can tell you that I reached out to OIG and received a response from them. They were unable to be here today but the delay is not with KARES but it is with the Kentucky State Police.

They do have a backlog with some new requirements that are due to the school systems in Kentucky. And their current estimate is that they'll be caught up in late October. And that's all the information.

MR. STEWART: I know recently it took about 17 days, which is not too bad.

MR. CHRISTMAN: Okay.

MR. CALLEBS: And that's for the criminal background check for hiring purposes. So is that -- we can't add to the workforce crisis that already exists by delaying two weeks.

MR. HARVEY: Delays in the person getting started and going through all of their training.

MR. CHRISTMAN: And in the meantime they get a different job.

MS. ELSTUN: Exactly. We've had that happen. Waiting on the background check and they end up getting a different job.

MS. DAVIS: We're seeing a six- to eight-week response time. And when I called them, because we did our 25 percent random criminal background checks in June, and we just got them.

So I called and they said there was a backlog because there was something with teachers needing them annually now instead of initial upon hire. But during our audits they've told us that as long as -- you have your 30 days to get your central registry check, that's the one that we're talking about that's being delayed. If you can show that you have mailed it, even if it's not back within 30 days, it doesn't fall on us.

So what I do on the central registry is I write the date I mailed it and then our check

number on it so that we can show that it's been cashed or whatever. And it has sufficed so we don't have to delay someone getting hired because of the backlog.

MS. KRIES: For the central registry?

MS. DAVIS: For the central registry, yes. Because the AOC and the nurse is the one that's due before. The CAN is the one that's delayed right now.

MR. CALLEBS: So not the criminal record check but the CAN checks are delayed?

MS. CLARK: When I reached out I was told the KARES.

MS. DAVIS: So maybe both.

MS. ELSTUN: We've had issues with the KARES coming back.

MR. STEWART: So as a provider it sounds like as long as 30 days then you can hire them despite the CAN not being back?

MS. DAVIS: From my understanding of what DDIDS told us is that as long as I show that I've mailed that in, and I have my other criminal background checks back, then it's safe as long as I show proof.

But KARES is a little bit different it's

a one shop -- you can use KARES which has all of the criminal background checks in one swoop or you can do the other where you run them individually. We run them individually and that's why we were able to.

MR. STEWART: Because I think that's the way Centerstone, I presume they run them individually. But we're being told until they both come back we're not allowing you to hire anybody.

MS. DAVIS: And that may be their own personal policy.

MR. STEWART: Yeah. But it's nice to know you have the flexibility as individual providers to go ahead and proceed on with hiring.

MS. DAVIS: Typically we do get them back before 30 days. I think it's just right now, it's my understanding with the school system it's kind of a backlog.

MR. CHRISTMAN: Alicia, did you find out the number of people?

MS. CLARK: 6,739 is on the Michelle P. waiver waiting list.

MR. CHRISTMAN: Unless someone else

has something they would like to discuss?

MR. EARL GRESHAM: I have one item. For those of you that don't know, Pam Smith is our new Division Director.

MR. CALLEBS: And there's a new Medicaid Commissioner.

MR. EARL GRESHAM: Yes.

MR. CALLEBS: Should invite her to the meeting.

MR. CHRISTMAN: All right. Then we're adjourned. Thank you.

(MEETING ADJOURNED AT 11:25 a.m.)

STATE OF KENTUCKY)
COUNTY OF FAYETTE)

I, SUSAN R. ELSENSOHN, Certified Court Reporter and Notary Public, State of Kentucky at Large, certify that the facts stated in the caption hereto are true; that said testimony was taken down in stenotype by me and later reduced to typewriting, by computer, under my direction, and the foregoing is a true and complete record of the testimony given.

My commission expires: September 9, 2022.

In testimony whereof, I have hereunto set my hand and seal of office on this the day of , 2018.

SUSAN R. ELSENSOHN
Certified Court Reporter
Notary ID No. 606854
Notary Public, State-at-Large